IDAHO DEPARTMENT OF HEALTH & WELFARE

PCS Children's Assessment Service Plan

INSTRUCTIONS

Incomplete or incorrect Service Plans will be returned and may result in a delay of the prior authorization for services.

The following instructions must be followed when completing the Service Plan

1. A new or updated Service Plan must be completed with each Annual Assessment
2. Print legibly
3. The child must have Medicaid services
4. All sections must be completed
5. Attach a copy of the most current Behavioral Service Plan and/or the Qualified Intellectual Disabilities Professional (QIDP) plan for children with behavioral challenges
6. The Service Plan must be developed in conjunction with the parent/guardian and their signature and date obtained
7. A current H&P and the signed Primary Care Provider Statement of Need documentation must be submitted.
8. EPSDT documentation is required for more than 16 hours of Personal Care Services

CLIENT INFORMATION

Client Name		Medicaid #	
Address		City	
Home Phone		Date of Birth	
State		Zip	
Parent Name		Phone	
Assessment Date		Next Review Date	
Region		Assessment Type	

PROVIDER

Name	Phone

CONTACTS

Contact	Relationship	Phone

GENERAL INFORMATION

ACTIVITIES OF DAILY LIVING (ADL)

Adaptive Devices	Refers to child's ability to manage putting on and removing braces, splints and other assistive devices. List the devices other than wheelchairs (see item 10 for wheelchairs).	**Available Support:**	**Score:**

Devices - Please select all that apply	Braces	Splints	Prosthesis

Frequency		Daily		Weekly		Monthly		As Needed

Written Care Plan:

Bathing	Refers to the child's ability to bathe or shower. Bathing or showering means running the water, getting in and out of the tub or shower and washing all parts of the body including shampooing hair.	**Available Support:**	**Score:**

Method – Please select all that apply	Bed	Shower	Tub	Stool	Other

Frequency		Daily		Weekly		Monthly		As Needed

Written Care Plan:

Bladder	Refers to the child's ability to control bladder functions.	**Available Support:**	**Score:**

Method - Please select all that apply	Toilet	Bedpan	Commode	Diaper	Indwelling Catheter	Intermittent Catheter

Frequency		Daily		Weekly		Monthly		As Needed

Written Care Plan:

Bowel	Refers to the child's ability to control bowel functions.	**Available Support:**	**Score:**

Method – Please select all that apply	Toilet	Bedpan	Commode	Diaper	Ostomy

Frequency		Daily		Weekly		Monthly		As Needed

Written Care Plan:

Dressing Lower Body	Includes undergarments, pants, socks and shoes.	**Available Support:**	**Score:**

Method – Please select all that apply	Braces	Splints	Other Assistive Devices

Frequency		Daily		Weekly		Monthly		As Needed

Written Care Plan:

Dressing Upper Body	Includes undergarments, pullovers, front opening shirts and blouses, zippers and snaps.	**Available Support:**	**Score**

Method – Please select all that apply	Braces	Splints	Other Assistive Devices
Frequency	Daily	Weekly	Monthly	As Needed

Written Care Plan:

Eating Meals	Refers to the process of eating, chewing and swallowing meals and snacks. Not preparing food to be eaten.	**Available Support:**	**Score:**

Method – Please select all that apply	Oral	G-Tube	Oral and G-Tube
Frequency	Daily	Weekly	Monthly	As Needed
Method – Please select all that apply	Oral	G-Tube	Oral and G-Tube
Frequency	Daily	Weekly	Monthly	As Needed
Meals	Breakfast	Lunch	Supper	Snack

Written Care Plan:

Grooming	Refers to the child's ability to tend to personal hygiene needs (e.g. washing face and hands, hair care, shaving, oral care, fingernail and toenail care).	**Available Support:**	**Score:**

Hair Care – Please select assistance	Independent	Supervise/Cue	Partial Assist	Total Assist
Oral Care – Please select assistance	Independent	Supervise/Cue	Partial Assist	Total Assist
Shaving/Make-up	Independent	Supervise/Cue	Partial Assist	Total Assist
Fingernail/Toenail Care – Please select assistance	Independent	Supervise/Cue	Partial Assist	Total Assist
Handwashing – Please select assistance	Independent	Supervise/Cue	Partial Assist	Total Assist
Frequency	Daily	Weekly	Monthly	As Needed

Written Care Plan:

Medications	(IDAPA 16.03.10.303.01.e) Assisting the participant with physician-ordered medications that are ordinarily self-administered in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing" Subsection 490.05.	**Available Support:**	**Score:**

Method – Please select all that apply	Oral	G-Tube	Rectal	Topical
Frequency	Daily	Weekly	Monthly	As Needed

Written Care Plan:

Mobility	Refers to the child's ability to move between locations from a standing position or to use a wheelchair once in a seated position on a variety of surfaces, includes power wheelchairs.	**Available Support:**	**Score:**

Wheelchair Transfer	Independent	Supervise/Cue	Partial Assist	Total Assist
Bedbound/Position Changes	Independent	Supervise/Cue	Partial Assist	Total Assist
Equipment	Gait Belt	Hoyer Lift	Transfer Board	Crutches
Electric Wheelchair	Cane	Walker	Manual Wheelchair	Braces
Services	Physical Therapy		Occupational Therapy	
Other Special Care				
Frequency	Daily	Weekly	Monthly	As Needed

Written Care Plan:					
Toilet	Refers to how well the child can manage using the toilet, bedpan or urinal. Includes adjusting clothing, getting on and off the toilet, cleaning oneself, changing pad, managing ostomy or catheter.			**Available Support:**	**Score:**
Method – Please select all that apply	Toilet	Commode	Ostomy	Bedpan	Diaper
Bowel Program					
Frequency	Daily	Weekly	Monthly	As Needed	
Responsible Party					
Written Care Plan:					
Transferring	Refers to all the child's physical ability (e.g. bed to chair) except tub (and toilet.			**Available Support:**	**Score:**
Wheelchair Transfer	Independent	Supervise/Cue	Partial Assist	Total Assist	
Bedbound/Position Changes	Independent	Supervise/Cue	Partial Assist	Total Assist	
Equipment	Gait Belt	Hoyer Lift	Transfer Board	Crutches	
Electric Wheelchair	Cane	Walker	Manual Wheelchair	Braces	
Services	Physical Therapy		Occupational Therapy		
Other Special Care					
Frequency	Daily	Weekly	Monthly	As Needed	
Written Care Plan:					

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Housekeeping	Refers to the child's ability to do chores, clean own bathroom, playroom or pick up after self.			**Available Support:**	**Score:**
Frequency	Daily	Weekly	Monthly	As Needed	
Written Care Plan:					
Laundry	Identify the child's ability to do any part of their laundry (excludes ironing).			**Available Support:**	**Score:**
Frequency	Daily	Weekly	Monthly	As Needed	
Written Care Plan:					
Medical Escort	Accompanying the child to clinics, physician's office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment.			**Available Support:**	**Score:**
Frequency	Daily	Weekly	Monthly	As Needed	
Written Care Plan:					
Preparing Meals	Refers to opening containers, cutting meat and meal set-up (e.g. breakfast cereal or toast; lunch, soup or sandwich; able to reheat in			**Available Support:**	**Score:**

	microwave or stovetop).							
Frequency		Daily		Weekly		Monthly		As Needed
Written Care Plan:								
Shopping	Includes brief occasional trips in the local community to shop for medical necessities required specifically for health and care of the recipient.					**Available Support:**		**Score:**
Frequency		Daily		Weekly		Monthly		As Needed
Written Care Plan:								

DELEGATED MEDICAL CARE

Dressing Changes	(IDAPA 16.03.10.303.01.e) Assisting the participant with physician-ordered medications that are ordinarily self-administered in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing" Subsection 490.05.							
Delegation – please identify who will provide the service								
Protocol								
Frequency		Daily		Weekly		Monthly		As Needed
Written Care Plan:								

Other Specialized Treatments	(IDAPA 16.03.10.303.01.e) Assisting the participant with physician-ordered medications that are ordinarily self-administered in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing" Subsection 490.05.							
Delegation – please identify who will provide the service								
Protocol								
Frequency		Daily		Weekly		Monthly		As Needed
Written Care Plan:								

BEHAVIORAL MANAGEMENT

Please describe the mental status/behavior problems which must be addressed and the plan to meet the child's needs
Instructions:

SIGNATURES

I acknowledge this Service Plan was developed with input from me and is the Plan to be followed in delivering care to my child:			
Parent/Guardian/Responsible Party		**Date**	
I acknowledge this Service Plan was developed by me and is the Plan to be followed in delivering care to this child			
Agency Nurse Signature		**Date**	